STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Under Arkansas Law, if you are a competent adult age 18 or older, you have the right to participate in making your own medical treatment decisions, including the right to accept or refuse specific forms of health care. As one means of exercising this right, the law allows you to complete written declarations containing instructions as to the kinds of health care decisions you wish to have made on your behalf if you become terminally ill or permanently unconscious and unable to make such decisions on your own. These declarations serve much the same purpose under Arkansas law as "living wills" serve in other states. To be effective, the declaration(s) must be signed by the patient or by someone else acting at his/her direction and must be witnessed by two individuals.

Any physician or other health care provider who is unwilling to carry out the instructions of a patient or health care proxy under the law has an obligation to take all reasonable steps necessary to transfer the care of such patient to another physician or health care provider who will do so.

Refer to Attachment 4.34-A, Page 2, for a copy of the Declaration Form to be used for residents of Arkansas.

STATE Arkansas
DATE REC'D 11-22-91
DATE APPV'D 12-2-91
DATE EFF 12-1-91
HCFA 179 91-55

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For Residents of ARKANSAS

STATE ARKANSAS

DECLARATION

(In the Event of a Terminal Condition)

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to:

(CHECK ONE BOX)

☐ 1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

DECLARATION

(In the Event of Permanent Unconsciousness)

If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act to:

(CHECK ONE BOX)

☐ 1. Withhold or withdraw life-sustaining treatments that are no longer necesary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

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